Cutaneous Metastasis from Endometrial Adenocarcinoma Case Report and Literature Review

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Abstract

Cutaneous metastases from endometrial adenocarcinoma are very rare, the incidence is unknown. We report a case of 60 year old patient treated from endometrial carcinoma stage IIB, she presented cutaneous metastasis six months after, an association of chemotherapy and radiotherapy were instituted. The tumor reaches the skin by variety of mechanisms, and there are several morphologic types. The treatment is based on local excision. The chemotherapy and radiation have also been utilized.

Introduction

Cutaneous metastases from cancer are rare in clinical practice. The incidence has increased from 2.7 in 1969 to 10% in recent year. Gates identified 58 cases of cutaneous metastasis from 2279 autopsy studies after cancer (1). It is often localised on the trunk and extremities. Rasbach et al (2)and Damewood et al (3) reported an incidence of 1.1% of skin metastases of endometrial carcinoma between 1889 and 1977. We reported a case of cutaneous metastases of endometrial adenocarcinoma and literature review.

Case Report(s)

A 60-year-old, menopausal for 12 years, operated for endometrial adenocarcinoma grade I, classified IIB according to the TNM classification; she has undergone hysterectomy and bilateral adnexectomy. The patient was lost sight of; she did not receive additional treatment. Six months later, she consulted for cutaneous mass measuring 6/3 cm next to the midline laparotomy scar without inflammatory signs (figure 2). Surgical excision of the tumor was made. Histological study confirmed an adenocarcinoma infiltrating dermis and hypodermis (figure 2). The patient received chemotherapy based Dxorubicin (60 mg/m²) and cisplatin (50mg/m²) with radiotherapy (50Gy).

Discussion

Cutaneous metastases of endometrial cancer are very rare. The incidence is unknown. Often the skin sites are the abdominal wall, vulva and the anterior chest wall (4). The primary tumors that most often metastasize to skin were melanoma (18%), lymphoma (14%), breast cancer (12%), gastrointestinal-stomach and colon (10,7%), pulmonary (8,9%), urinary tumors (7%) and others (17%) (5). Carcinoma metastasizes to skin by different mechanisms including direct extension, lymphangitic or hematogenous spread. There are two forms, the first is post chirurgical due to the direct extension of the tumor and can be incisional, trochar site or drain site metastases. The other form, usually indicating end stage disease and poor prognosis, it is due to natural history of the cancer. Often, the implantation of tumor cells in the skin is facilitated by obliteration of small lymphatic channels after radiation therapy. Different morphologic types are described including macules, papules, nodules, indurated or purpuric plaques. Over 22 cases of umbilical metastases (Sister Mary Joseph’s nodules) have been reported from women with endometrial primaries and it is due to direct extension of the primary tumor (6). The treatment strategies include local excision (if feasible) and chemotherapy (Dxorubicin, cisplatin, 5fluorouracil and Melphalan). Others treatments: Progestagens, paclitaxel, Tamoxifen and radiation have also been utilized. No change has been noted in prognosis with any particular treatment.

References

Illustrations

Illustration 1

Figure 1: tumor mass next to the laparotomy scar
Illustration 2

Figure 2: histological study showed infiltration dermis by adenocarcinoma.
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